ARIZONA STATE BOARD OF HEALTH Vol. 9-27 # 175

BUREAU OF VITAL STATISTICS

(This return should preferably be made by the person who made the original).

SUPPLEMENTARY REPORT OF BIRTH Local Registrar's No.*.....

Place of Birth (Registration District) Globe County Gila No. Cedar St.

SEX OF CHILD *	Twin / Triplet or other?	and	Number * in order of birth
Male			

DATE OF BIRTH* September 29th 192 7
(Month) (Day) (Year)

	FATHER
FULL* NAME	Carl G. Carlson

	MOTHER
FULL* MAIDEN NAME	Edith Erickson

I HEREBY CERTIFY that the child described herein has been named

Carl Alfred Carlson
(Given name in full) (Surname)

C. G. Carlson
(Father's or Mother's Signature)

G B Madsen M.D.
(Signature of Physician or Midwife)

*These items to be entered by the local registrar before giving out this form.

Blank supplemental reports of birth may be obtained from the local registrar.
Local registrars must mail supplemental reports immediately to state registrar.

PLEASE WRITE PLAIN AND IN INK.

Supplementary report must be returned within 15 days

This supplemental report is to be pasted beneath the original.

20-25